

cases. In several lacerations of the vaginal wall occurred, which were immediately closed by catgut stitches. Six of the patients had rhachitic pelvis; one an obliquely contracted pelvis. Two were primiparæ, five multiparæ, and one of these had the operation the second time. In three labor was ended by forceps, in four by version. Six women and all the children recovered. One woman died.

The patient who died was a primipara who had albuminuria. The wound was found united apparently, but on further study was discovered to be infected. In the peritoneum were found pure cultures of the colon bacillus. In the symphysis were streptococci, staphylococci, and colon bacilli, and in the uterus the same germs were present.

#### **The Use of the Curette in Subinvolution During the Puerperal State.**

—In the *Archiv f. Gynäkologie*, 1898, Bd. 55, Heft ii., KNAPP reports his experience in cases of subinvolution in which he has curetted the uterus during the puerperal state.

His patients were twelve in number. None of them had fever after childbirth, and there was no adequate cause for subinvolution which could be detected. All ordinary methods of securing involution had been faithfully tried. As indications for the operation, the following were considered sufficient: First, the retention of placenta or membranes within the uterus; second, the failure of other methods to secure involution; third, when the patient could not wait for prolonged involution to occur. Many working women could not afford to remain in the hospital a sufficient length of time without operation.

It is especially interesting to note that no adequate cause was found in all these cases for failure of involution. The exact manner in which the placenta was removed seemed to make no difference. Neither rapid nor slow labor seemed to influence involution. It was as common after premature birth as after labor at term.

The general health of the patient, however, had a marked influence upon involution. If the patient was strong and well, subinvolution rarely occurred. In primiparæ involution took a longer time, but was more complete when finished. In multiparæ it was not so perfect. Fever, excessive distention of the uterus during pregnancy, and all obstetric operations seemed to favor subinvolution. Repeated examinations during labor had the same effect. Especially important in securing good involution was the emptying of the bladder and rectum during the puerperal period. Where these were allowed to become distended, the uterus failed to contract. In cases where placenta or membranes were retained, the blunt curette was employed, but where hypertrophied decidua was present a sharp curette was used. The operation was based upon the size of the uterus, the condition of the cervix, and the condition of the lochial discharge. When the womb was large and soft, when the cervix was either partly open or tightly contracted and the lochial discharge was not red or serous, the case was considered a proper one for curetting. The occurrence of bloody lochia alone was not thought a sufficient cause. Knapp is accustomed to examine his patients ten days after labor, and if involution is not properly proceeding, curetting is performed. He is accustomed first to introduce a sound to determine the

size of the uterus, and observed that this is sometimes followed by contraction of the womb. He calls attention to the fact that the womb may be high in the abdomen and still involution have gone on well.

His cases all improved rapidly and were discharged cured six days after the curetting. Ergotin was given after the operation with good results.

---

**Ectopic Gestation.**—In the *Boston Medical and Surgical Journal*, May 12, 1898, SWIFT reports two interesting cases of ectopic gestation. In the first, a young woman recently married had symptoms of ectopic gestation, but no tumor could be found on vaginal examination. Membrane was discharged from the uterus, which Dr. Whitney pronounced characteristic decidua. On abdominal section, the right tube was found behind the uterus in such a position that it could not have been felt by vaginal examination. It contained an early embryo. The second case was that of a primipara who had an abdominal gestation with pseudo-labor and death of the child. Six weeks afterward Swift removed the foetus and appendages. The patient made a good recovery. Whitney adds to this clinical report an interesting description of the decidual cells found in the first case and of the foetus removed in the second.

---

**Successful Antiseptic Precautions.**—In the *Wiener klinische Wochenschrift*, No. 18, 1898, MARS describes the antiseptic precautions which he employs in Krakau. His results are excellent, a mortality of 0.4 of 1 per cent. for all cases in 700 patients, and a septic mortality of 0.28 of 1 per cent. His methods are practically to disturb the patient as little as possible. No douches before or after labor are given. The thighs and external parts are thoroughly scrubbed with soap and water and lysol. The hands of those who make examinations are very carefully cleaned, and the hand is always wet with antiseptics when the examination is made. Lacerations are closed immediately after labor. All operations or interference are done under strictly antiseptic precautions.

---

**Cæsarean Section, with Transverse Incision of the Fundus.**—SCHROEDER (*Monatsschrift für Geburtshülfe und Gynäkologie*, 1898, Band vii., Heft 2) reports the case of a primipara with contracted flat pelvis, at full-term pregnancy. The patient elected Cæsarean section, with prevention of further conception. At operation the womb was opened by transverse incision of the fundus. The broad ligaments were ligated, the womb amputated, and stump covered with peritoneum and dropped. Bleeding was detected near the left sacro-iliac joint, with formation of retro-peritoneal hæmatoma. The peritoneum was incised, the clot turned out, and the vessel tied; bleeding promptly ceased. During recovery there was slight fever, tenderness over the stump, and infiltration of the tissues about the stump. This gradually disappeared, and recovery followed.

His next operation was for osteomalacia, and was a typical cœlio-hysterectomy, with intrapelvic treatment of the stump; recovery was delayed by a mild catarrhal pneumonia; the patient ultimately regained good health.

Case third was a rhachitic imbecile, with flat, rhachitic pelvis. This patient had been long in labor, and had been examined by a number of doctors and midwives. The child was dead, and the amniotic liquid dis-